PRINTED: 12/09/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILI	DING		(c
		185379	B. WING			07/2	9/2011
	OVIDER OR SUPPLIER OUNTY HEALTH CARE	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 IEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	conducted on 07/27-2 substantiated. Immediate identified to exist from On 04/07/11, at 2:00 to have bright red rec to have rectal bleeding the hospital 24 hours AM. However, the phothesignificant change Resident #1 was obstanount of hard stool enemas, one "Fleets" Magnesium" were adwithout a physician's 24-hour timeframe. For the hospital on 04/08/07/07/07/07/07/07/07/07/07/07/07/07/07/	AM, Resident #1 was noted tal bleeding and continued g until being transported to later, on 04/08/11, at 2:15 hysician was not notified of a in the resident's condition. Berved to have a large and three "Soap Suds" enema, and "Citrate of ministered to the resident, order, during this same Resident #1 was admitted to 1/11, with rectal bleeding and sfusion upon admission to ident experienced severe altiple occasions during the occumentation revealed a made to repair rectal tears 04/26/11, Resident #1 respiratory failure, was a on a mechanical ventilator. Subated after showing no in the ventilator, experienced			Past noncompliance: no plan of correction required.		
LABODATODY		egation of neglect to all			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUII			(
		185379	B. WIN	G		07/2	9/2011
	OVIDER OR SUPPLIER OUNTY HEALTH CARE	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224		
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F 000	aware of the incident developed and imple 04/14/11-06/21/11, to It was determined the	e 1 encies. After becoming , the facility immediately mented interventions from o correct the deficiencies. e facility had completed all or to the State Agency	F	000			
F 157	initiating the investiga	ation on 07/27/11, thus nation of Past Jeopardy. Y OF CHANGES	F	157			
	consult with the resid known, notify the resid known, notify the residence or an interested familiaccident involving the injury and has the pointervention; a significantly in existing form of the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a).	commence a new form of sion to transfer or discharge facility as specified in					
	and, if known, the resor interested family no change in room or rospecified in §483.15 resident rights under	promptly notify the resident sident's legal representative nember when there is a ommate assignment as (e)(2); or a change in Federal or State law or led in paragraph (b)(1) of					

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		185379	B. WIN		·		9/ 2011
	OVIDER OR SUPPLIER	FACILITY	,	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224		
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F 157	the address and phor legal representative of legal representative of the second representation of the s	rd and periodically update ne number of the resident's or interested family member. It is not met as evidenced record review, and facility determined the facility failed system to ensure staff the resident's physician perienced a significant or one of nine sampled 1). The facility failed to the Changes in a Resident's policy/procedures to ensure an was notified immediately perienced a significant on 04/07/11, at 2:00 AM, ced a significant change in eding and continued to have time of transfer to the rear on 04/08/11, at 2:15 AM. It to notify the resident's ent's rectal bleeding. Ditalized on 04/08/11, bleeding due to a rectal ne hospital on 05/07/11. Baused, or is likely to cause, mpairment, or death to y, to include Resident #1. ardy was determined to exist tinued until 06/22/11. The corrective action which was	F	157	Past noncompliance: no plan of correction required.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185379	B. WING		07/:	C 29/2011	
	OVIDER OR SUPPLIER	FACILITY	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	Condition or Status p 01/09/03, revealed N responsible to notify the physician when: a) The any accident/incident including injuries of under was a significant chain physical, mental, emostatus; c) The resident treatment/medication alter the resident's treatment/medication alter the resident's treatment/medication had been maresident from the faci authority; and/or f) Denecessary/appropriates resident. A review of Resident revealed the facility and 01/19/10. Review of orders revealed the remilligrams (mg) once once a day (anti-plate blood clotting). Review of Resident # 04/07/11, at 2:00 AM Nurse (LPN) #2 was room due to Resident bleeding. The note replaced onto the bed, impaction which reve	y's Changes in a Resident's olicy/procedure, dated ursing Services was the resident's attending the resident was involved in that resulted in injury, nknown source; b) There age in the resident's obtional or psychosocial at refused; d) There was a need to eatment significantly; e) A add to transfer/discharge the lity without proper medical emed e in the best interests of the #1's medical record dmitted the resident on Resident #1's medication esident received Aspirin 325 a day and Plavix 75 mg elet agents used to inhibit #1's nurse's note dated arevealed Licensed Practical summoned to the shower that the transfer deceived Resident #1 was	F 157				

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185379	B. WIN	G			© 9/2011	
	ROVIDER OR SUPPLIER	FACILITY	•	RC	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 157	2:35 AM, revealed the bowel movement and "gapped open" with "s noted." The note furt enema was administed. Review of Resident # 04/07/11, at 2:05 AM, administered one-hal Magnesia" through the tube (G-tube). The nesident's blood presersident's pulse was respiration was 18. Onurse's notes dated of PM documented by Lassisted the State Reto place the resident note revealed staff of rectum to have "bleed Suds" enema was addocumentation, "loose pushing out" a small I documentation reveal have rectal bleeding at Review of the nurse's 9:30 PM, seven and of previous note, revealed to Resident #1's room to have "rectal bleed rectum gaped open, to revealed LPN checked impaction and a large."	esults noted. In note dated 04/07/11, at a resident had not had a the resident's rectum was some blood clolts (clots) her revealed a "Fleets" ered by LPN #2. I's nurse's note dated revealed LPN #2 for a bottle of "Citrate of e resident's Gastrostomy ote documented the sure was 88/57, the 120, and the resident's Continued review of the 14/07/11, from 7:00 AM-7:00 PN #1, revealed the LPN gistered Nurse Aide (SRNA) on his/her left side. The eserved the resident's ding (spots)," and a "Soap ministered which, based on ened feces enough to start bowel movement. The led Resident #1 continued to lat 2:00 PM, "from enema." In note dated 04/07/11, at one-half hours after the led LPN #2 was summoned in, and observed Resident #1 mod amount of blood note ry to pass stool." The note	F	157				

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		185379	B. WIN				C 9/2011
	ROVIDER OR SUPPLIER			RO	ET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224	<u> </u>	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	on documentation, LF Suds" enema to the results and "bright recresident's rectum wer Further review of the at 1:45 AM, revealed large amount of blood 2:15 AM on 04/08/11 observed Resident # bleeding, the resident hospital for evaluation. The review of Resider revealed no documer staff attempted to not of the significant char condition from 04/07/04/08/11, at 2:15 AM transported to the hospital for evaluation. An interview conduction with Licensed Practic Resident #1's physicing resident #1's rectal bleed was out of state and a have instructed her to monitor the resident, interview revealed the #1's rectal bleeding at (LPN #1) who worked An interview conduction with LPN #1 revealed LPN #2 did not report experienced rectal bleeding and provided the provided that the provided t	PN #2 administered a "Soap esident and "medium" d" bleeding from the re noted. nurse's note dated 04/08/11, Resident #1 was "having d clolts, pad saturated." At a 30 minutes after LPN #2 if had "bright red" rectal at was transported to the local in of the rectal bleeding. Int #1's medical record inted evidence that facility iffy the resident's physician inge in the resident's 11, at 2:00 AM, until in, when the resident was spital. Bed on 07/27/11, at 5:20 PM, all Nurse (LPN) #2, revealed an was not notified of the ding because the physician according to the LPN, would be administer an enema and which she had done. The ele LPN reported Resident and hard stool to the LPN if the following shift. Bed on 07/27/11, at 6:21 PM, if on 04/07/11, during rounds at that Resident #1 had beeding during the night. The PN #1 went to Resident #1's	F	157			

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	IG			9/ 2011
	OVIDER OR SUPPLIER			F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	07723	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	attempting but unable movement, and LPN to administer an ener the resident to have a However, LPN #1 sta syringe could not be i rectum due to the har at around 2:00 PM, R medium bowel mover blood were observed revealed LPN #1 faile Resident #1's change An interview conducte with State Registered revealed on 04/07/11 "Soap Suds" enema a resident was observe meaty clots of blood to LPN stated she observed I pool of blood, really n resident's condition to revealed LPN #2 cheet the resident would "be she reported the resident would	to have a bowel #1 and SRNA #2 attempted ha to the resident to enable bowel movement. ted the tip of the enema hiserted into the resident's dened stool. LPN #1 stated esident #1 had another hent and a "few spots" of at that time. The interview d to notify the physician of in condition. ed on 07/27/11, at 10:17 PM, Nurse Aide (SRNA) #5 h LPN #2 administered the hand following the enema, the d by SRNA #5 to have "little hand SRNA #5 reported the hand SRNA #5 reported the heaty," and reported the heaty," and reported the h LPN #2. The interview heat Resident #1 and said he all right." SRNA #5 stated hent's condition to LPN #4, hent #1 and said the resident hered to the hospital for heatment. ed on 07/28/11, at 9:20 AM, han SRNA reported to him helbeding; he assessed the held a moderate amount of he resident's incontinence	F	157			

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	ROVIDER OR SUPPLIER	FACILITY	,	ROI	ET ADDRESS, CITY, STATE, ZIP CODE UTE 908 PO BOX 1718 EZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	An interview conduct with the Director of N had always been the physician of any char According to the DON reach the physician tiresident to the hospit doubt, send them out LPN #2 should have 04/07/11, at 2:00 AM exhibited the bright related the bright related to the hospit telephoned the facility receive report of any to the residents. In a revealed the physician was out of #1's Primary Physician other physicians who physician was out of #1's Primary Physicia been informed Resid bleeding and was trathe following week. Would have expected and that the resident hospital for evaluation revealed the adminisincreased the resider would have been everectal bleeding to the A review of a Hospital	ed on 07/27/11, at 5:05 PM, ursing (DON), revealed it facility's policy to notify the nge in a resident's condition. N, if a nurse was unable to the nurse should transfer the all for evaluation or "when in the interview revealed notified the physician on the when Resident #1 first and rectal bleeding. I on 07/28/11, at 12:05 PM, Resident #1's Primary the Physician was out of cident related to Resident #1 cian reported he had by twice a day, every day, to problems/concerns related ddition, the interview of was in practice with two were "on-call" when the town/unavailable. Resident an confirmed he had not ent #1 experienced rectal insported to the hospital until The Physician stated he the nurse to report if a bright red rectal bleeding would be transported to the n. The interview also tration of Aspirin and Plavix it's risk for bleeding, and an more reason to report the	F	157			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	G	·		© 9/2011
	ROVIDER OR SUPPLIER	FACILITY		F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	1 01/2	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	revealed the resident blood transfusion due of 8.0 (reference range Hematocrit (HCT) of 202-52). On 04/11/11, a colonoscopy was proposed and verge was full of the rectum which was inferior surface of the any clot," and "active posterior surface of the tear in the rectal wall centimeter, which is a on a piano). The revirence of the entrangence of the ent	al bleeding. The summary immediately received a to Hemoglobin (HGB) level ge 13.5-18.0) and 26.9 (reference range three days after admission, erformed and revealed "the a large amount of blood in seremoved," "an ulcer on the rectum about 2 cm without bleeding coming from the ne rectum which was a large measuring 1 X 2 cm" (cm = about the size of a black key ew revealed on 04/26/11, and Acute Bradycardia (slow eats per minute) and irratory arrest, was intubated, thanical ventilator. The esident #1 expired on the intention of the control of t	F	157			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185379	B. WIN				C 29/2011	
	COUNTY HEALTH CAR	E FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 157	notified of any change. This monitoring was (Monday-Friday) and in charge (in the abs Saturday and Sunday and Saturday and Saturday and Sunday and Saturday and Sunday and Set (MDS) Coolinector (SSD) bega 24-hour shift reports to identify any reside and ensure the physmonitoring will be or Beginning 05/03/11 meeting was held evall department head change of condition notified. This monito **The surveyor valid taken by the facility Interview with the D 07/29/11, at 4:02 PM all resident records notification/signification/signification/signification notification of discrepance residents' medical rephysician notification. Review of facility in-04/15/11 and 05/04/was in-serviced on president had a change (Monday States).	ensure the physicians were ges in the residents' condition. It conducted daily by the DON of the Registered Nurse (RN) sence of the DON) on ay. This monitoring will be ON, Administrator, Minimum ordinator, and Social Services an a daily review of the sand new physician's orders ent with a change in condition sician had been notified. This ingoing. In a weekly quality of care every Thursday, consisting of some storing will be ongoing. Itated the corrective action as follows: ON and Administrator on of the corrective had audited related to physician and ches. Record review of eight ecords revealed appropriate	F	157				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	iG_			9/ 2011
	COUNTY HEALTH CARE	FACILITY		R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	#3; on 07/28/11, at 9: 07/28/11, at 9:20 AM, each had attended an notification of a reside. Interviews on 07/29/1 and at 2:05 PM, with (the weekend charge reviewed the shift reporders. Following the charge nurse made reresidents with problem condition had been recondition had been recondition had been recondition had been recondition. Review of the meeting 07/29/11, at 4:02 PM, Administrator, and MI they meet daily to revand new physician on was notified of any recondition. Review of the meeting 07/29/11, at 4:02 PM, Administrator, and MI they meet weekly in a physician notification condition was include. Review of minutes from the recondition was included. Review of minutes from the recondition was included.	nsed Practical Nurses (LPN) 10 AM, with RN #1; and on with LPN # 4, revealed they in-service on physician ent's change in condition. 1, at 4:02 PM, with the DON Registered Nurse (RN) #2 nurse), revealed they ort and new physician's reviews, the DON or ounds to identify/assess as to ensure any change of eported to the physician. If minutes and interview on with the DON, If coordinator revealed iew the 24-hour shift report ders to ensure the physician sident with a change of If minutes and interview on with the DON, If coordinator revealed if minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If coordinator revealed If minutes and interview on with the DON, If minutes and interview on with the DON and		224			

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F 224	policies and procedur	elop and implement written es that prohibit , and abuse of residents	F:	224			
	by: Based on interview, it policy, it was determine an effective system to policies/procedures the residents for one of in (Resident #1). The fat followed the Resident to ensure residents reservices to avoid physelogous 2:00 AM, Resident #1 bleeding and continue until transferred to the 2:15 AM. Facility stat treatment/evaluation is bleeding for 24 hours hospitalized on 04/08 bleeding due to a recident on 05/07/11. The failure to seek meresident has caused, injury, harm, impairment and other residents in Jeopardy was determined to the continued until 06 and continued	nat prohibit neglect of ine sampled residents acility failed to ensure staff a Protection policy/procedure exceived the necessary sical harm. On 04/07/11, at experienced rectal ed to have rectal bleeding to hospital on 04/08/11, at fineglected to seek for the resident's rectal. Resident #1 was 1/11, diagnosed with rectal tal tear, and expired at the edical attention for a or is likely to cause, serious ent, or death to Resident #1 in the facility. The Immediate ined to exist on 04/07/11,			Past noncompliance: no plan of correction required.		

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F 224	Past Jeopardy. The findings include: A review of the facility policy/procedure (no would review the daily report), conduct nursi routine observations in eglect. The policy's prevention programs on all shifts to identify toward residents. The would assess, care p with needs and behaving editor and the facility PM-7:00 AM shift on Resident #1 had recta administered an ener 7:00 AM-7:00 PM shifts on Service and	e State Agency's 7/11, thus it was determined 7's Resident Protection date) revealed the facility y nursing report forms (shift ng rounds, and make to identify the potential for tated the abuse/neglect included monitoring of staff y inappropriate behaviors the review revealed the facility lan, and monitor residents yiors that may lead to the policy, neglect was the rices necessary to avoid 7's shift report for the 7:00 04/06/11-04/07/11, revealed al bleeding and was ma. The shift report for the ft on 04/07/11, revealed a was administered at 10:30 unt of bowel movement and ent had a medium bowel the shift report failed to	F	224			

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	OVIDER OR SUPPLIER	FACILITY	ROL		EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	AM, revealed the resi open" with "some bloch Continued review revon 04/07/11, on the 7 the resident's rectum documentation revea bleeding at 2:00 PM, administered. During 04/07/11, a nurse's number of the resident was bleed mod amount of open, try to pass stoch administration of a "Simedium results noted continued to have bleed from the rectum. On Resident #1 was obstamount of blood clotts was "saturated." The medical record from 04/08/11, at 2:15 AM, evidence that facility is treatment for Resider the timeframe of 24 h Resident #1 was tranfor evaluation of rectal 2:15 AM. An interview conducted with State Registered revealed on 04/07/11 #1 to the shower and onto the floor of the sidented LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed con 104/07/11 #1 to the shower and onto the floor of the sidented LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed con 104/07/11 #1 to the shower and onto the floor of the sidented LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed con 104/07/11 #1 to the shower and onto the floor of the sidented LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed revealed LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed LPN #2 admired revealed revealed LPN #2 admired revealed LPN #2 ad	detion on 04/07/11, at 2:35 dent's rectum was "gapped od clolts (clots) noted." ealed LPN #1 documented :00 AM-7:00 PM shift, that was "bleeding (spots)." The led Resident #1 also had after an enema had been	F	224			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185379	B. WIN				୦ 9/ 2011
	ROVIDER OR SUPPLIER	FACILITY	1	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	was observed to have SRNA stated she fou pool of blood, really no reported the resident interview revealed LF and voiced no concercondition. The SRNA condition to LPN #4. #4 assessed Resider resident needed to be An interview conduct with Licensed Practic confirmed SRNA #5 ro4/07/11, at approxim Resident #1 was have resident was in the state LPN, Resident #1 hardened stool in the administered. Accord was observed to have bleeding after the energial Resident #1's physicic concerning the reside interview revealed the #1's rectal bleeding at to the oncoming LPN approximately 7:00 A occurrence on the sh when she returned to 04/07/11, she received LPN that had worked AM-7:00 PM, that Re experience rectal bleed An interview conductivith LPN #1 revealed to the province of the short with LPN #1 revealed the with LPN #1 revealed the short with LPN #1 revealed the s	e "little meaty clots." The nd the resident in a "large neaty" on 04/08/11, and s condition to LPN #2. The "N #2 checked Resident #1 ms related to the resident's According to SRNA #5, LPN at #1 and determined the e transferred to the hospital. ed on 07/27/11, at 5:20 PM, al Nurse (LPN) #2, eported to the LPN on nately 2:00 AM, that mg rectal bleeding while the nower room. According to was also observed to have rectum and an enema was ding to LPN #2, the resident e "a speck or two" of ema. LPN #2 verified an was not consulted ent's rectal bleeding. The e LPN reported Resident and hardened stool in rounds (LPN #1) on 04/07/11, at M, and documented the eff report. LPN #2 stated work at 7:00 PM on and no information from the on 04/07/11, from 7:00 sident #1 continued to	F	224			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	ON (X3) DATE SURVE COMPLETED	
		185379	B. WIN	G			C 9/ 2011
	ROVIDER OR SUPPLIER	FACILITY	'	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	LPN #2 had reported experiencing rectal bit approximately 2:00 P medium bowel movel of blood due to the st. An interview conducted with LPN #4, confirmed him that Resident #1 the resident and obseinght red blood on the pad. Interviews conducted and 4:00 PM, with Resident and elephoned the factor receive report of an related to the resident stated he would have report any incidents of bleeding the resident transported to the hosinterview revealed the and Plavix increased bleeding and would he to report the resident physician. The interview physician concern bleeding was neglect resident's treatment. A review of a Hospital	ort from LPN #2 and that nothing about Resident #1 eeding. LPN #1 stated at M, Resident #1 had a ment and had a "few spots" ool being so hard. ed on 07/28/11, at 9:20 AM, ed a SRNA had reported to was bleeding; he assessed erved a moderate amount of e resident's incontinence on 07/28/11, at 12:05 PM esident #1's Primary e was out of town during the surred with Resident #1, but excility twice a day, every day, my problems/concerns to in his care. The physician expected the nurse to of a resident experiencing ding and stated in the event ent would have been espital for evaluation. The end administration of Aspirin the resident's risk for ave been even more reason is rectal bleeding to the iew revealed, in the ne failure of staff to consult hing the resident's rectal	F	224			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	COVIDER OR SUPPLIER	L		F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	1 07/2	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	the hospital on 04/08/bleeding for two days upon admission the received a blood transevealed on 04/11/11 performed and reveal bleeding coming from rectum which was a lameasuring 1 X 2 cm review revealed on 04 developed Acute Braisuffered cardiac/resp and placed on a medisummary revealed Reco5/07/11. Interviews conducted at 12:30 PM, and at 32 President of Clinical Conducted a "stand u reviewed the 24-hour "rounds" to observe a residents that were id According to the DON "rounds" the DON was care/services were president of Clinical Conducted to Resident # President of Clinical Conducted to Resident # President of Clinical Conducted to Cover the modern and the cover the	111, due to having rectal . The summary revealed esident immediately stusion. Continued review, a colonoscopy was ed an ulcer and "active the posterior surface of the arge tear in the rectal wall (cm = centimeter). The 4/26/11, Resident #1 dycardia (slow heart rate), iratory arrest, was intubated, nanical ventilator. The esident #1 expired on on 07/28/11, at 10:10 AM, 1:20 PM, with the Vice Operations, the Director of the Administrator revealed ay through Friday, the DON p" meeting with the nurses, shift report and performed all residents and assess any entified to have "problems." It, during the review and s to ensure the appropriate rovided to address identified	F	224			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUF	ED
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	ROVIDER OR SUPPLIER	FACILITY		RO	ET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 EZ, KY 41224	1 01/2	572011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	-All resident records of Nursing (DON) and No concerns were for to abuse or neglect. -All licensed nursing staff was in-serviced 06/21/11, regarding a misappropriation. -On 05/03/11, as par quality assurance progress and new physician and new physician was notified a resident's condition care/services were pensure the residents' This monitoring will be the condition, and to ensure the necessar meetings began on the condition of the surveyor validation that the DO of the condition is the condition of the condi	were audited by the Director d Administrator on 04/22/11. und during the audit related staff and certified nursing on 06/03/11, and again on abuse, neglect, and t of the facility's ongoing orgam, the 24-hour nursing sician's orders were leeting with the DON, um Data Set (MDS) sial Services Director. The sted to identify any resident dition, to assure the d in the event of a change in and that appropriate rovided for residents to needs were not neglected. The engoing. Leting is held weekly, every any resident with a change in ure the residents have ary care and services. The 15/03/11, and will be ongoing.	F	2224			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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		185379	B. WIN	G			9/2011
	ROVIDER OR SUPPLIER	FACILITY		RC	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224	•	
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F 224	residents' medical reconcerns were identifineglect, or misappropressory revealed no neglect of Review of facility in-s 06/03/11, with Regist Licensed Practical Number Medication Technicial staff members were in abuse/neglect policy. In-service on 06/21/1 Nurse Aides and three members revealed that the abuse/neglect pompers revealed that the abuse/neglect pompers and the staff members revealed that the abuse/neglect pompers and 107/28/11, at 2:57 PM at 3:15 PM, revealed on the abuse/neglect Interview with the DC the MDS Coordinator and a review of qualification to ensure were provided and not review of minutes from the interview with the DC 07/29/11, at 4:02 PM of care meeting, on a any resident who had	cords were audited and no fied related to abuse, oriation of resident property. In residents' medical records occurred. ervice conducted on ered Nurses (RNs), urses (LPNs), and Certified ins (CMTs), revealed these in-serviced on the Review of the facility 1, with State Registered e other facility staff ey had been in-serviced on licy. Interviews with SRNA 15 PM; LPN #3 on 07/27/11, in 07/28/11, at 9:10 AM; LPN 20 AM; SRNA #4 on 07/28/11, they had been in-serviced policy. NN, the Administrator, and on 07/29/11, at 4:02 PM, by of care meeting minutes aily to review the 24-hour ew physician's orders to ange of condition/physician the necessary care/services	F	224			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185379	B. WING		C 07/29/2011	
	OVIDER OR SUPPLIER OUNTY HEALTH CARE	FACILITY	ROU	T ADDRESS, CITY, STATE, ZIP CODE ITE 908 PO BOX 1718 Z, KY 41224	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPI	(5) LETION LTE
F 224 F 225	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for other facility staff to the or licensing authorities. The facility must ensinvolving mistreatment including injuries of unisappropriation of reimmediately to the act to other officials in act through established particulations are thorough event further potent investigation is in proof the administrator of representative and to with State law (included certification agency) of the results of agency) of the administration agency) of the mistreatment of the administrator of the administration agency) of the mistreatment of the administration agency) of the mistreatment of the administrator of the admini	c)(2) - (4) DRT VIDUALS employ individuals who have abusing, neglecting, or by a court of law; or have l into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a an employee, which would service as a nurse aide or he State nurse aide registry es. ure that all alleged violations nt, neglect, or abuse, nknown source and esident property are reported dministrator of the facility and ecordance with State law procedures (including to the tification agency). e evidence that all alleged ghly investigated, and must tial abuse while the gress.	F 224 F 225			

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		185379	B. WIN				C 9/2011
	COVIDER OR SUPPLIER	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From page	÷ 20	F	225			
	by: Based on interview, a investigation review, a was determined the fareffective system to en involving neglect were and reported immedia and to the appropriate nine sampled residen facility failed to ensure Protection policy/produces was reported investigated. The fact the necessary care/seduring a 24-hour time was observed to have #1 was hospitalized or rectal bleeding due to the hospital on 05/07/several staff members Resident #1 had expet the necessary care had however, the staff memincident to administrate became aware of an auto-1/13/11, when the DB Based Services (DCE of alleged neglect related Administrator failed to failed to report the neappropriate state age.	and facility policy review, it acility failed to have an asure all alleged violations at the thoroughly investigated at the test agencies for one of the test agencies for the test agencies for Resident and the test agencies for Resident and the test agencies for Resident and the test agencies for			Past noncompliance: no plan of correction required.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		185379	B. WIN	G			9/ 2011
	COUNTY HEALTH CARE	FACILITY	,	R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	residents in the facility was determined to ex continued until 06/22/implemented corrective completed prior to the investigation on 07/27 Past Jeopardy had ex The findings include: A review of the facility policy/procedure (no violations of neglect in Administrator or the Expolicy stated any pers reason to believe that victim of neglect shall According to the policy provide goods/services physical harm or men occurs on an individual receives a lack of can according to the policupon receiving a report Administrator or the Expolicy and Regula Services, and other and According to the policupon receiving and Regula Services, and other and According to the policupon receiving to the policupon receiving and Regula Services, and other and According to the policular to the following completed Incident Rewith the person(s) regulators with the person(s) regulators with the resident's medical receives the following completed Incident Rewith the resident's medical receives affirmembers (on all	y. The Immediate Jeopardy ist on 04/07/11, and 11. The facility we actions which were a State Agency's 7/11, thus it was determined disted. It's Resident Protection date) revealed any alleged must be reported to the PON immediately. The son who has knowledge or a resident had been a report the offense. The son who has knowledge or a resident had been a report the offense. The review revealed at languish/illness. Neglect all basis when a resident at in one or more areas, we the review revealed for of neglect the PON will immediately report owing agencies: Division of tion, Adult Protective gencies as appropriate. The investigation shall generally and a review of the report Form; by An interview porting the incident; continued in the incident; continued in the incident; do resident; e) A review of the report of the incident; do resident; e) A review of the resord; f) An interview with shifts) having contact with the period of the alleged	F	225			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		185379	B. WIN	G		07/29	9/ 2011
	COUNTY HEALTH CARE	FACILITY		R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 225	A review of all circum incident. The policy r of participating in the be suspended withou investigation have be Administrator. The rethe investigation will be Abuse Investigation will be Abuse Investigation of Review of the facility's Resident #1, with no had developed a time incident but failed to staff involved, as per addition, the facility fa agencies had been not accordance with the formula of the facility fare and the incident but failed to staff involved, as per addition, the facility fare agencies had been not accordance with the formula of the facility fare agencies had been not accordance with the formula of the facility fare agencies had been not accordance with the following involved in the facility fare agencies had been not accordance with the following involved in the facility fare agencies had been not accordance with the facility fare agenci	mbers, and visitors; and h) stances surrounding the evealed employees accused alleged abuse/neglect will t pay until the findings of the en reviewed by the eview revealed the results of the recorded on the Resident Report form. Is investigation related to date, revealed the facility line of events related to the document interviews with the facility's policy. In illed to document all state of the allegation in accility's policy. #1's nurse's note dated revealed Resident #1 had as described as "bright red." and 04/07/11, at 2:35 AM, is rectum was "gapped od clolts (clots) noted." A //07/11, on the 7:00 AM-7:00 is resident's rectum had ne same note revealed some bleeding at 2:00 PM, een administered. The next //07/11, at 9:30 PM, was observed to have ount of blood note rectum is stool." LPN #2 ration of a "Soap Suds" results noted and that	F	225			

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	G			© 9/2011
	COUNTY HEALTH CARE	FACILITY	•	RC	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	had a "large amount or resident's underpad we revealed Resident #1 hospital for evaluation 04/08/11, at 2:15 AM. An interview conducted with State Registered revealed on 04/07/11 "dripping" onto the flot the SRNA reported the SRNA reported the "#2. The interview revealed to have SRNA stated on 04/0 in a "large pool of bloom reported the resident" interview revealed LF would "be all right." Some reported the resident "According to SRNA #Resident #1 and the interview conducted with Licensed Practic confirmed on 04/07/1 #5 reported Resident wo" of blood. The LF SRNAs reported Resident two" of blood. The LF SRNAs reported Resident whospital on 04/08/11.	at 5 AM, revealed Resident #1 of blood clolts," and that the was "saturated." The review was transported to the local in of rectal bleeding on ed on 07/27/11, at 10:17 PM, I Nurse Aide (SRNA) #5, Resident #1 had blood for of the shower room, and the resident's bleeding to LPN realed LPN #2 administered ing the enema, the resident es "little meaty clots." The 8/11, Resident #1 was found od, really meaty," and she is condition to LPN #2. The PN #2 stated the resident SRNA #5 stated she then is condition to LPN #4. 55, LPN #4 assessed resident was transported to ed on 07/27/11, at 5:20 PM, al Nurse (LPN) #2, 1, at around 2:00 AM, SRNA #1 was having rectal ew revealed the nurse and observed a "speck or PN stated on 04/08/11, the ident #1's rectal bleeding to borted the bleeding to LPN	F	225			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SU COMPLET	
		185379	B. WIN				C 29/ 2011
	ROVIDER OR SUPPLIER	FACILITY		RO	ET ADDRESS, CITY, STATE, ZIP CODE UTE 908 PO BOX 1718 IZ, KY 41224	0112	3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	with LPN #4, reveale that Resident #1 was he assessed the resimoderate amount of resident's incontinent. An interview conduct with SRNA #2 reveal "Soap Suds" enema the SRNA, she observesident's rectum, storeported the bleeding. A review of a Hospital 05/26/11, revealed R the hospital on 04/08 bleeding for two days the resident immedia transfusion upon adn colonoscopy was perulcer and active blee tear in the rectal wall 04/26/11, Resident # rate, suffered cardiac expired on 05/07/11. Interviews conducted at 12:30 PM, and at 3 President of Clinical Nursing (DON), and the Administrator and allegation of neglect DCBS initiated an invinterview revealed af medical record and ir involved, it was deter had not notified the p	d an SRNA reported to him bleeding. The LPN stated dent and observed a bright red blood in the ce brief. ed on 07/27/11, at 9:05 PM, ed Resident #1 received a con 04/07/11. According to rved spots of blood from the exped the enema, and to LPN #1. If Discharge Summary dated esident #1 was admitted to //11, for having rectal cells. The summary revealed telly received a blood hission. On 04/11/11, a formed and revealed and ding coming from a large. The review revealed on 1 developed a slow heart comparison of the Administrator revealed if DON became aware of the when a representative from restigation on 04/13/11. The ter reviewing Resident #1's	F	225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185379					0
	ROVIDER OR SUPPLIER	I		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224	07/29	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	orders. According to suspended for one da upon completion of the determined LPN #2's to Resident #1 and the 05/03/11. According 06/24/11, the facility of DCBS' investigation of guilty of caregiver neonotify the physician of change in condition a without a physician's suspended on 06/24/neither the Administrator the Administrator the Administrator state incident to DCBS facility aware of the acconfirmed the allegated Division of Licensing Inspector General (Onot considered the ininterview further revenot documented on the Investigation Report of the Administrator thad not been documented facility's policy. *The facility implemented correct the deficiency of Nursing (Director of Nursing (Direct	the DON, both LPNs were ay. The Administrator stated are investigation it was "actions were detrimental" are LPN was terminated on to the Administrator, on was informed by DCBS that found LPN #1 and LPN #2 glect due to the failure to concerning Resident #1's and for providing treatments order. LPN #1 was 11. The interview revealed after nor the DON felt that tended to neglect Resident aurses used poor judgment." atted the facility did not report because DCBS made the llegation. The Administrator ion was not reported to the and Regulation/Office of IG) because the facility had cident neglectful. The aled the investigation was ne Resident Abuse form and interviews with staff ented in accordance with the	F	225			

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			A. BUII		<u> </u>	(C
		185379	B. WIN	G		07/2	9/2011
	ROVIDER OR SUPPLIER COUNTY HEALTH CARE	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE COUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	nursing staff was in-s 06/21/11, regarding reconstruction of the vice President of reviewed and reiterated abuse/neglect prever reporting policy with the DON on 05/17/11 On 05/03/11, as part quality assurance proceed and new physic reviewed daily in a machinistrator, the Mir Coordinator, and the ensure residents recocare/services and all were reported. A weekly quality of control of the necessary care and the necessary care and began on 05/03/11, and ensure that all abuses reported. **The surveyor validate taken by the facility and the poor of problems identified.	staff and state registered erviced on 06/03/11 and eporting abuse/neglect. of Clinical Operations ed the facility's ation, investigating, and the facility Administrator and the facility Administrator and the facility Songoing agram, the 24-hour nursing sician's orders were eeting with the DON, the animum Data Set (MDS) Social Services Director to sived appropriate abuse/neglect incidents are meeting is held every my resident with a change in the residents have received and services. This monitoring and will be ongoing, to (neglect incidents are sted the corrective action is follows: and the Administrator on a revealed 100 percent of the cords were audited for abuse/neglect, with no record review of eight cords revealed no neglect.	F	225			

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AND PLAN OF CC	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		185379	B. WIN	G			୦ 9/ 2011
	IDER OR SUPPLIER JNTY HEALTH CARE I		I	R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	0112	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
R 06 Li Mication N m th #4 07 at or In th 07 care pl th at in In 07 in real of R in	6/03/11, with Register icensed Practical Nurser Identication Technician censed staff was insected buse/neglect policy. Inservice on 06/21/11 ursing Assistants and the abuse/neglect policy of 1 on 07/27/11, at 3:1 to 6:40 PM; RN #1 on 14 on 07/28/11, at 2:57 PM; to 3:15 PM, revealed the abuse/neglect policy. It is 1:15 PM, revealed the abuse/neglect policy. It is 1:15 PM, revealed the management of the Minimum Data Section 1 on 07/29/11, at 4:02 PM, are meeting minutes eview 24-hour nursing the policy. It is 1:15 PM, are meeting minutes eview 24-hour nursing the interview with the Admitterview of minutes from the abuse/neglect on 05/16 folinical Operations deview of minutes from the review of minutes from the review with the DOI of the review of minutes from the review with the DOI of the rev	n-service conducted on ered Nurses (RNs), rses (LPNs), and Certified as (CMTs) revealed the serviced on the Review of a facility I, with State Registered d three other facility staff ey had been in-serviced on icy. Interviews with SRNA 5 PM; LPN #3 on 07/27/11, 07/28/11, at 9:10 AM; LPN 10 AM; SRNA #2 on and SRNA #4 on 07/28/11, they had been in-serviced policy. N, the Administrator, and t (MDS) Coordinator on and review of quality of revealed they meet daily to g reports and new ensure residents received ervices and that any ons were reported and ininistrator and the DON on revealed they had been use/neglect policy to include ating any alleged 17/11, by the Vice President	F	225			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185379	B. WIN				9/ 2011
	OVIDER OR SUPPLIER	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 225	any resident who had condition and ensure provided. 483.20(k)(3)(i) SERV PROFESSIONAL ST. The services provided	weekly basis, to discuss experienced a change of appropriate care was ICES PROVIDED MEET		225			
	by: Based on interview, review, and review, and review of (KRS) 314.011, it was failed to have an effer provided services that standards of quality for residents (Resident # ensure staff followed policy/procedure to entreatments/medication were ordered by the pod/07/11-04/08/11, fathree "Soap Suds" en and one-half of a bott to Resident #1 without Resident #1 experient timeframe of approximate before/during and after was administered, be hospital on 04/08/11, Resident #1 was hospital on outper at the staff process.	or one of nine sampled 1). The facility failed to the Physician Orders nsure all ns administered to residents ohysician. On cility staff administered nemas, one "Fleets" enema, le of "Citrate of Magnesium" at a physician's order. ced rectal bleeding for a mately 24 hours er the enemas/medication fore being transported to the due to rectal bleeding. oitalized on 04/08/11, bleeding due to a rectal ne hospital on 05/07/11.			Past noncompliance: no plan of correction required.		
	This failure has cause	ed, or is likely to cause,					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		185379	B. WIN				C 29/2011
	COUNTY HEALTH CARI	E FACILITY	•	F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 281	Resident #1 and oth The Immediate Jeop on 04/07/11, and co facility implemented were completed pricinvestigation on 07/2 Jeopardy was determined the findings included Review of KRS 314. Practical Nursing properformance of acts such as are taught of schools for practical and caring for the ill direction of a register physician, or dentist applying procedures as defined and auth administration of meauthorized by a physician, or advanced Teaching, supervisin limited by the board other nursing acts where the board. A review of the facility policy/procedures (or residents' medication ordered by a license stated all medication resident must be orderedicty, medication, or dedication, ded	impairment, or death to er residents in the facility. bardy was determined to exist intinued until 06/22/11. The corrective actions which or to the State Agency's 27/11, and as a result, Past mined.	F	281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUII	DING		Ι ,	С
		185379	B. WIN	G			9/2011
	ROVIDER OR SUPPLIER	FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	physician. Review of Resident # 04/07/11, at 2:00 AM having bright red rect revealed Resident #1 Practical Nurse (LPN large amount of hard Documentation revea was administered by dated 04/07/11, at 2:: had not had a bowel resident's rectum was blood clolts (clots) no enema was administe A review of the nurse 2:45 AM, revealed LF of a bottle of 'Citrate of through Resident #1's Continued review rev 04/07/11, on the 7:00 #1, which revealed the noted to have "bleedi administered a "Soap Nursing documentation 9:30 PM, LPN #2 was #1's room, the reside moderate amount of resident's rectum was checked the resident amount of soft to hard lower bowel. LPN #2 enema was administe continued to have "br	et's nurse's note dated revealed Resident #1 was al bleeding. The note was checked by Licensed #2 for an impaction and a stool was noted. #3 saled a "Soap Suds" enema the nurse. The nurse's note #3 AM, revealed the resident movement and the #3 "gapped open" with "some ted." At that time, a "Fleets" ered by LPN #2. "s note dated 04/07/11, at PN #2 administered one-half of Magnesia' (laxative) #3 Gastrostomy tube. #4 ealed a nurse's note dated #4 AM-7:00 PM shift by LPN #5 resident's rectum was #5 ng (spots)" and LPN #1 #6 Suds" enema. #5 Suds" enema. #6 on revealed on 04/07/11, at #6 summoned to Resident #6 nt was observed to have a #6 rectal bleeding, and the #6 s"gaped open." The nurse #6 for an impaction and a large #6 distool was noted in the #6 documented a "Soap Suds"	F	2281			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185379	B. WIN	G		07/29	9/ 2011
	ROVIDER OR SUPPLIER	FACILITY	1	R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 281	"Soap Suds" enemas administer the 'Citrate Documentation revea transferred to the hos AM, due to rectal blee An interview conducte with LPN #2 confirme three enemas and "C Resident #1 on 04/07 stated the facility had included interventions enema, a "Fleets" ene of Magnesia." LPN # of the need for a phys the interventions on the An interview was conducted and at 4:00 PM, with Physician confirmed had facility staff related to enemas and/or medic Resident #1. The physhould never be administered in the physhould never be administered and at the physhould never be administered by the physhould never by the physhould never be administered by the physhould never by the physhou	in's order to administer the the the "Fleets" enema, or to be of Magnesium." Ided Resident #1 was pital on 04/08/11, at 2:15 eding. Ided on 07/27/11, at 5:20 PM, dishe had administered itrate of Magnesium" to 1/11-04/08/11. The LPN a bowel program which as such as a "Soap Suds" ema, "Lactulose," and "Milk 2 stated she was unaware sician's order to administer the bowel program/protocol. Iducted with LPN #1 on and confirmed the LPN and to Resident #1 on 1/11 (it in the left) was for a physician's order to 1/12 (it in the left) was for a physician's order to 1/12 (it in the left) was not contacted by the administration of cations (Laxatives) for 1/12 (it in the left) was resident #1 on 1/12 (it in the left) was not contacted by the administration of 1/12 (it in the left) was not contacted by 1/12 (it in the left) was not contacted	F	281			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	ED
		185379	B. WIN	G			୦ 9/2011
	ROVIDER OR SUPPLIER	FACILITY		F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	0772	5/2011
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	the facility's policy ne medications or treatmorder. The DON states uspended for one datreatments without a A review of a Hospital 05/26/11, revealed Rethe hospital on 04/08 for two days. The sureceived a blood tran 04/11/11, a colonoscerevealed an ulcer and from a large tear. Th 04/26/11, Resident # rate, suffered cardiac expired on 05/07/11.	ian's orders for the occording to the DON, it was ver to administer any nents without a physician's ed LPN #1 and LPN #2 were ay due to providing physician's order. I Discharge Summary dated esident #1 was admitted to //11, due to rectal bleeding mmary revealed the resident sfusion upon admission. On opy was performed and a active bleeding coming e review revealed on 1 developed a slow heart //respiratory arrest, and	F	281			
	records were audited appropriate physician identified. -In-services were con 05/04/11, by the Direlicensed nursing staff orders for all medicat facility's bowel protoc -On 05/03/11, the fact the 24-hour nursing rorders to ensure all tr	dent records and bowel to ensure all treatments had 's orders, with no problems ducted on 04/15/11 and ctor of Nursing (DON) for all on obtaining physician's ions/treatments and the ol. ility initiated monitoring of eports and new physician's reatments had physician's the daily during a meeting					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WIN				С
		185379				07/2	9/2011
	COUNTY HEALTH CARE	FACILITY		R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 281	be ongoing. -On 05/03/11, a quality DON, the Administrate (MDS) Coordinator, a Director was held were residents that had receive were physician's. This monitoring will be "*The surveyor validataken by the facility as Interview on 07/29/11 and the Administrator audit of resident chart 04/22/11, to verify all orders by the physicial eight residents' medicatreatments had the approvement of the physician change of condition. Inservice on 05/04/15 been in-serviced on of the physician when a condition. Interview we 4:02 PM; Licensed Pr 07/27/11, at 6:40 PM; on 07/28/11, at 9:20 AM, been in-serviced on the physical of the physical of the physical when a condition. Interview we 4:02 PM; Licensed Pr 07/27/11, at 6:40 PM; on 07/28/11, at 9:20 AM, been in-serviced on the physical of the physical o	ry of care meeting with the or, the Minimum Data Set and the Social Services ekly on Thursday, to identify derived treatments to ensure a corders for the treatments. The done monthly. It det the corrective action are follows: In at 4:02 PM, with the DON revealed a 100 percent are had been completed on treatments had proper and documented. Review of all records revealed all peropriate physician's In a service dated 04/15/11, and been in-serviced on an when a resident had a Review of a facility and bearing physician's orders attion and the need to notify resident had a change in with the DON on 07/29/11, at actical Nurse (LPN) #3 on Registered Nurse (RN) #1 AM; and LPN #4 on revealed facility staff had	F	281			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
			A. BUIL			(
		185379	B. WING	Э <u> </u>		07/2	9/2011
	OVIDER OR SUPPLIER OUNTY HEALTH CARE	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 281	Continued From page	e 34	F 2	281			
F 309	with the DON, the Ad Coordinator on 07/29 they meet daily to rev report and new physi resident who received physician's order. Review of minutes from interview with the DC 07/29/11, at 4:02 PM of care meeting, on a any resident who had orders for the treatmed 483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must reprovide the necessar or maintain the higher mental, and psychoso	RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,	F3	309			
	by: Based on interview, policy review, it was of to have an effective s provided the necessar the highest practicab of nine sampled resid				Past noncompliance: no plan of correction required.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SUF	ED
		185379	B. WIN	G			୦ 9/2011
	ROVIDER OR SUPPLIER	FACILITY		ROU	T ADDRESS, CITY, STATE, ZIP CODE TE 908 PO BOX 1718 Z, KY 41224	07723	5/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	resident experienced condition and that a condition and continued to have transferred to the hose 04/08/11, at 2:15 AM notify the resident's prectal bleeding and facomprehensive assess Resident #1 was hose diagnosed with rectal tear, and expired at the transferred to exist out the facility's failure to received the necessal caused, or is likely to impairment, or death residents in the facility determined to exist out the state Agency's in the Immediate Jeopa Past Jeopardy. The findings include: A review of the facility Condition or Status polyogo3) revealed N responsible to notify the physician when a resignificant change in there was a need to see the state of the state of the significant change in there was a need to see the state of the state of the state of the state of the facility condition or Status polyogo3) revealed N responsible to notify the significant change in the was a need to see the state of the state o	d immediately when the a significant change in comprehensive assessment lition was conducted. On Resident #1 experienced a condition of rectal bleeding erectal bleeding until being spital 24 hours later, on The facility staff failed to hysician of the resident's liled to conduct a sament of Resident #1. pitalized on 04/08/11, bleeding due to a rectal ne hospital on 05/07/11. In ensure each resident ry care/services has cause, serious injury, harm, to Resident #1 and other y. Immediate Jeopardy was no4/07/11, and continued acility implemented ich was completed prior to vestigation on 07/27/11, thus rdy was determined to be It's Changes in a Resident's olicy/procedures (dated ursing Services was the resident's attending ident experienced a physical status or when	F	309			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED				
			A. BUII	DING			C
		185379	B. WIN	G			9/2011
	ROVIDER OR SUPPLIER	FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 IEZ, KY 41224	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	resident experiences condition, the assess conduct a compreher resident's condition. A review of Resident revealed the facility a 01/19/10. Review of orders revealed the milligrams (mg) once once a day (both anti inhibit blood clotting). most recent Minimum comprehensive asses Assessment (CAA) s 02/03/11, revealed the resident's increas of blood) by the co-ac Aspirin. Review of Resident # 04/07/11, at 2:00 AM summoned to the show #1 having bright red in revealed Resident #1 checked for impaction hard stool noted, and administered with simulations. The next nurse's note AM, revealed the resimovement and the resignated of the resimovement and the resignated of the shown and the resignated of the resimovement and the resignated of the resignated of the resimovement and the resignated of the resimovement and the resignated of the resimovement and the resignated of t	a significant change in ment coordinator would nsive assessment of the #1's medical record dmitted the resident on Resident #1's medication esident received Aspirin 325 a day and Plavix 75 mg -platelet agents used to Review of Resident #1's a Data Set (MDS) esment and Care Area aummary both dated e facility failed to address ed risk of hemorrhage (loss administration of Plavix and et al. The note was placed onto the bed, in with a large amount of a "Soap Suds" enema all results noted.	F	3309			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		185379	B. WIN	IG			C 9/2011
	COUNTY HEALTH CARE	FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 IEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	AM-7:00 PM shift reversident to his/her left rectum was observed and a "Soap Suds" end The documentation recontinued to have blet the administration of 9:30 PM, LPN #2 observed and a "Soap Resident's rectum was administered a "Soap Resident #1 continued. The next nurse's note AM, revealed Resident blood clots from the repad under the resider review revealed Resident blood clots from the repad under the resider review revealed Resident blood lots from the repad under the resider review revealed Resident blood clots from the repad under the resider review revealed Resident blood lots from the repad under the resider review revealed Resident for an outling of the resident #1's penange in the resider conduct a compreher. An interview conducted with Licensed Practic confirmed Resident #04/07/11 and 04/08/11, an outline of the resident's physician would be provided the resident's physician would be provided the resident's physician would be provided to the resident's physician would be provided the resident's physician would be provided the resident's physician would be physician would	on on 04/07/11, for the 7:00 realed LPN #1 assisted the a side, noted the resident's to have "bleeding (spots)," mema was administered. Revealed Resident #1 reding at 2:00 PM, following the enema. On 04/07/11, at served Resident #1 to have a rectal bleeding and the served seven and noted do to bleed from the rectum. The determinant of the incontinence of the was "saturated." The dent #1 was transported to revaluation of rectal bleeding AM. Based on a review of the one of the significant of the signifi	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		185379	B. WIN	G			C 9/ 2011
	COUNTY HEALTH CARE	FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	due to observation of resident's rectum. LP approximately 2:00 Phad a bowel moveme blood" observed. An interview conducted with LPN #4 revealed on 04/08/11, and obsiding the desident #1 was transfurther assessment/trule interviews conducted and 4:00 PM, with Rephysician revealed he any change in a resid bright red rectal bleed Resident #1 received which increased the rand would have been report rectal bleeding to the physician, an eadministered to a residued in interview conducted with the DON and the Administrative staff wuntil 04/13/11; therefore assessment was conducted the deficiency	and administered an enema hardened stool in the PN #1 stated at M on 04/07/11, Resident #1 nt with a "few spots of Ped on 07/28/11, at 9:20 AM, he assessed Resident #1 erved a moderate amount of the resident's incontinence of following his assessment protected to the hospital for eatment. On 07/28/11, at 12:05 PM asident #1's Primary the expected nurses to report ent's condition, including ling. The physician stated Aspirin and Plavix daily, esident's risk for bleeding, even more of a reason to to the physician. According nema should never be ident experiencing rectal ed on 07/28/11, at 10:10 AM, and Administrator, revealed as unaware of the incident ore, no comprehensive ducted.	F	309			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						
			A. BUII			(С
		185379	B. WIN	G		07/29	9/2011
	COVIDER OR SUPPLIER	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	assessments, with no lineservices were pro 05/04/11, for all licens notification/significant assessments. -A system was put int DON to review the 24 physician's orders, Mensure physician noti were appropriately performs these duties. This monitoring will be seginning on 05/03/10 ongoing quality assur Administrator, the Mir Coordinator, and the meet on a daily basis review the 24-hour nuphysician's orders, in resident with a change physician had been no resident's condition, appropriate assessments.	g (DON) and the to physician a change in condition and o concerns identified. Vided on 04/15/11 and sed staff regarding physician a change in condition and seesawents and the DON's absence. The charge nurse is in the DON's absence. The charge nurse is in the DON's absence. The charge nurse is in the DON, the part of the facility's cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the DON, the part of the facility is cance program, the part of the facility is cance program, the DON, the part of the facility is cance.	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUII B. WIN			(
		185379	B. WIIV			07/29	9/2011
	OVIDER OR SUPPLIER OUNTY HEALTH CARE	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From page	e 40	F	309			
	tests and falls/restrain	udies related to diagnostic nts/physician notification and d in May and June 2011, and for 12 months.					
	**The surveyor valida taken by the facility as	ted the corrective action s follows:					
	and the Administrator resident charts were a notification and asses identified. Review of	, at 4:02 PM, with the DON revealed 100 percent of audited related to physician sement with no issues eight resident records physician notification and					
	the DON on 07/29/11 07/27/11, at 6:40 PM; AM; and LPN #4 on 0 revealed they had be	en in-serviced on the need n and the MDS Coordinator rienced a change in a comprehensive					
	and RN #2 (the week 07/29/11, at 2:05 PM, 24-hour shift reports a	N on 07/29/11, at 4:02 PM, end charge nurse) on , revealed they reviewed the and new physician's orders ary care/services were					
	on 07/29/11, at 4:02 F Administrator, and the	eting minutes and interview PM, with the DON, the e MDS Coordinator revealed riew the 24-hour nursing shift					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	G			C 9/2011
	OVIDER OR SUPPLIER	FACILITY		R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 IEZ, KY 41224	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	physician notification conducted on any reschange in condition. Review of minutes ar and the Administrator revealed the facility hometing to discuss an experienced a chang appropriate physician assessments were concept to the facility improvement (CQI) and the Administrator revealed during the normal condition of the areas of diagnost which included physician's orders. 483.75 EFFECTIVE ADMINISTRATION/FA A facility must be admenables it to use its refficiently to attain or	sician's orders to ensure and assessments were sident who experienced a sident who had a weekly quality of care so resident who had a of condition to ensure a notification and sonducted. Continuous Quality and interview with the DON on 07/29/11, at 4:02 PM, sonoths of May and June ance study was completed in its tests and falls/restraints, cian notification and seesile sident with the sources effectively and maintain the highest mental, and psychosocial		309			
	by: Based on interview, facility policies, it was failed to be effectively	record review, and review of determined the facility refficiently administered in a led the highest physical			Past noncompliance: no plan of correction required.		

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
			B. WIN			_	
		185379				07/29	9/2011
	DER OR SUPPLIER	FACILITY		R	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
We (R eff po far as re co state tre er invago of the co pe be out to the control to th	Resident #1). The far fective system in place of the sessed and notified sident experienced and iton. The Admin aff obtained a physic extrements/medication is idents. In addition, insure allegations of a consideration and report of the sident's rectal bleeding and consideration in the sident's rectal bleeding and consideration in the sident's rectal bleeding and consideration in the sident's rectal bleed of the facility's policy of the facility's policy of the facility's policy of the facility's policy of the facility in the sident #1 and failed and report the alleged at a gencies. Resident #1 and failed the facility in the sident #1 and failed at a gencies. Resident #1 and expire in the facility in the sident #1 and failed at a gencies. Resident #1 and expire in the facility in the sident #1 and failed at a gencies. Resident #1 and expire in the facility in the sident #1 and failed at a gencies. Resident #1 and expire in the facility in the fa	nine sampled residents acility failed to have an ace to ensure facility ere implemented. The n failed to ensure staff I the physician when a a significant change in istration failed to ensure cian's order for ns prior to administering to n, the Administration failed to neglect were thoroughly rted to the appropriate state AM, Resident #1 ant change in condition of ontinued to have rectal red to the hospital 24 hours 2:15 AM. The facility staff ident's physician of the ling and failed to conduct a isment of Resident #1 as act. The Administrator neglect allegation on resentative from the nunity Based Services vestigation involving d to thoroughly investigate I neglect to the appropriate dent #1 was hospitalized on with rectal bleeding due to a	F	490			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SUF	
			A. BUIL				С
		185379	B. WIN	3		07/2	9/2011
	ROVIDER OR SUPPLIER	E FACILITY		ROU	T ADDRESS, CITY, STATE, ZIP CODE ITE 908 PO BOX 1718 Z, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	The Immediate Jeo on 04/07/11, and co facility implemented were completed prinvestigation on 07/ was determined to The findings include A review of the faci Condition or Status 01/09/03) revealed responsible to notify physician when a rechange in physical alter the resident's policy stated when significant change in coordinator would cassessment of the A review of the faci policy/procedures (residents' medication or stated all medication resident must be or resident's attending policy, medication, treatment may not like without the written aphysician. A review of the faci policy/procedure, walleged violation of	her residents in the facility. pardy was determined to exist continued until 06/22/11. The discorrective actions which or to the State Agency's (27/11; therefore, the Jeopardy be Past Jeopardy.	F	490			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	IG			C 9/2011
	COUNTY HEALTH CARE	FACILITY	•	R	EET ADDRESS, CITY, STATE, ZIP CODE OUTE 908 PO BOX 1718 NEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 490	the failure to provide avoid physical harm, review revealed upon neglect, the Administri immediately report the agencies: Division of Regulation/Office of It Adult Protective Servi appropriate. The poli should consist of the completed Incident R with the person(s) regulaterviews with any wan interview with the resident's medical restaff members (on all the resident during the incident; g) Interviews roommate, family mean A review of all circum incident. The review would identify the pot reviewing the daily nuconducting nursing resolved in the resident with the pot reviewing the daily nuconducting nursing resolved in the resident would identify the pot reviewing the daily nuconducting nursing resolved in the resident with the resident would identify the pot reviewing the daily nuconducting nursing resolved in the resident was also bleeding. At 2: revealed the resident open" with "some block Resident #1 was also bleeding at 2:00 PM of dated 04/07/11, at 9:30 observed a moderate	ey, neglect was defined as goods/services necessary to mental anguish/illness. The receiving a report of rator or the DON would e incident to the following Licensing and respector General (OIG), ices, and other agencies as cy revealed the investigation following: a) A review of the eport Form; b) An interview porting the incident; c) itnesses to the incident; d) resident; e) A review of the cord; f) An interview with shifts) having contact with e period of the alleged is with the resident's mbers, and visitors; and h) stances surrounding the also revealed the facility ential for neglect by ursing report forms,	F	490			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	
		185379	B. WIN				C !9/2011
	COUNTY HEALTH CARE	FACILITY	 	ROI	ET ADDRESS, CITY, STATE, ZIP CODE UTE 908 PO BOX 1718 Z, KY 41224		3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	"bright red" bleeding note dated 04/08/11, Resident #1 had a "la and the pad underne "saturated." The revi was transported to the evaluation of rectal b AM. Based on a revi record, there was no attempted to notify the significant change in 04/07/11, at 2:00 AM. The documentation reassessment of Resid 2:00 PM until 9:30 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11. Interviews conducted 12:30 PM, and 3:20 PM assessment of the re 04/08/11.	resident continued to have from the rectum. A nurse's at 1:45 AM, revealed arge amount of blood clolts," ath the resident was ew revealed Resident #1 e local hospital for leeding on 04/08/11, at 2:15 ew of Resident #1's medical evidence facility staff e resident's physician of the the resident's condition from a until 04/08/11, at 2:15 AM. Evealed there was no lent #1 on 04/07/11, from and then no further sident until 1:45 AM on level of the president with the Vice President is, the Director of Nursing instrator revealed the le DON became aware of an when a representative of lestigation on 04/13/11, at 10:10 AM, and then no further is the reviews were conducted the leviewed Resident #1's interviews were conducted in the resident's care.	F	490			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	
		185379	B. WIN	IG			୦ 9/ 2011
	ROVIDER OR SUPPLIER		I	F	REET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 NEZ, KY 41224	01123	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	facility aware of the a confirmed the allegation Division of Licensing Inspector General (Oconsider the incident revealed every morning DON met with the nurshift report, and obseto identify concerns reaccording to the DON the appropriate care/sto ensure the physicial changes in a resident revealed the DON was the incident and there effect to perform the cabsence. Review of the facility's timeline of the incident the facility's investigatinterviews with staff into Resident #1 during In addition, the facility indicate the allegation appropriate state age *The facility implement correct the deficiency by the Director of Nur Administrator to ensure were reported/investigment professional stant-On 05/17/11, the Vicensident -On 05/17/11, the Vicensid	allegation. The Administrator on was not reported to the and Regulation/Office of IG) because she did not neglectful. The interviewing, Monday thru Friday, the rese, reviewed the 24-hour reved all residents in an effort elated to the residents. If she attempted to ensure services were provided and an was notified of any resonation. The interviews is on vacation the week of ewas no backup system in duties of the DON in her sinvestigation revealed a not had been documented but the time of the allegation. The interview is investigation of care the time of the allegation. The interview is investigation did not in had been reported to the noties. The interview of the allegation of the allegation of the time of the allegation of the noties.	F	490			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) DATE S COMPL	.ETED
		185379	B. WING	3	07	C // 29/2011
	COUNTY HEALTH CARE	FACILITY		STREET ADDRESS, CITY, STATE, ZIP CO ROUTE 908 PO BOX 1718 INEZ, KY 41224	•	72072011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 490	and reporting of negle Administrator and the Administrator and the DON and the Administrator and the O6/21/11, regarding a investigation, and reported and 05/04/11, for all I physician notification experienced a changer A system was put in required the DON to report and new physician through Friday, to ensprovided and neglect weekends the charger This monitoring systems.	policy, including investigating ect allegations, with the eDON. Staff was in-serviced by the strator on 06/03/11 and abuse prevention, porting. Indicensed staff regarding when a resident e in condition. In place on 04/22/11, and review the 24-hour shift cian's orders on Monday sure appropriate care was did not occur. On the enurse performs the tasks. In will be ongoing.	F	490		
	physician's orders we meeting with the DON Minimum Data Set (N Social Services Direct with a change in concephysician was notified were provided, and a reported to Administration 05/03/11. -The department heat weekly quality of care review any resident were meeting with the concephysician was notified were provided, and a reported to Administration 05/03/11.	enursing reports and new ere reviewed daily in a N, the Administrator, the MDS) Coordinator, and the effort to identify any resident dition and assure the d, appropriate care/services ny neglect issues were ation. This process began ds will participate in a elementing on Thursdays to with a change in condition to have received the necessary				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185379	B. WIN	G			୦ 9/2011	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			,	RO	EET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE		
F 490	care and services. To 05/03/11, and will be -All investigations will Director within two wo and reviewed in the meeting to ensure all abuse/neglect preven reporting were met. **The surveyor validataken by the facility as Interview with the DO 07/29/11, at 4:02 PM, residents' medical recreporting incidents of problems identified. Frecords revealed approxification and assess Interview on 07/29/11 and the Administrator in-serviced on 05/17/1 abuse/neglect policy in reporting by the Vice Operations. Review of the facility 06/03/11, with Registe Licensed Practical Number Medication Technicial licensed staff was insabuse/neglect policy. in-service on 06/21/11 Nursing Assistants ar members revealed the	be reviewed by the Medical orking days of completion nonthly quality assurance components of tion, investigation, and ted the corrective action is follows: N and the Administrator on revealed 100 percent of the cords were audited for abuse/neglect, with no review of eight resident repriate physician issments. , at 4:02 PM, with the DON revealed they had been in the facility regarding investigating and president of Clinical in-service conducted on the red Nurses (RNs), inses (LPNs), and Certified ins (CMTs), revealed the serviced on the	F	490				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185379	B. WING			C 07/29/2011		
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY				RO	ET ADDRESS, CITY, STATE, ZIP CODE DUTE 908 PO BOX 1718 EZ, KY 41224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 490	at 6:40 PM; RN #1 or #4 on 07/28/11, at 9:2 07/28/11, at 2:57 PM at 3:15 PM, revealed on the abuse/neglect Review of a facility in 04/15/11 and 05/04/1 was in-serviced on phresident had a chang 07/29/11, at 4:02 PM at 6:40 PM, with Lice #3; on 07/28/11, at 9:20 AM each had attended ar Review of minutes froincluding quality of cawith the DON, the Ad Coordinator on 07/29 they had met daily to reports and new physresidents' change of notification to ensure allegations were reported at 2:05 PM, revealed shift reports to ensure provided and no incidoccurred. A form was DON; however, the Degun using the form	15 PM; LPN #3 on 07/27/11, on 07/28/11, at 9:10 AM; LPN 20 AM; SRNA #2 on and SRNA #4 on 07/28/11, they had been in-serviced policy. service conducted on 1, revealed all licensed staff hysician notification when a se in condition. Interviews on with the DON; on 07/27/11, onsed Practical Nurse (LPN) 10 AM, with RN #1; and on with LPN # 4 revealed they in-service training.	F	490				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185379	B. WING			C 07/29/2011	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			•	ROUT	ADDRESS, CITY, STATE, ZIP CODE TE 908 PO BOX 1718 , KY 41224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 490	07/29/11, at 4:02 PM of care meeting on a resident who had exp condition and ensure provided. Interview with the DC 07/29/11, at 4:02 PM Director would review abuse/neglect within	revealed they had a quality weekly basis to discuss any perienced a change of appropriate care was N and the Administrator on revealed the Medical any investigations of two working days; however, ports of abuse/neglect and	F	190			